NEWS AND NOTES

Views

Journalists' smears are no new phenomenon, so Minerva was pleased to read in the *Journal of the Royal College of Physicians of London* (1979, **13,** 221) C E Newman's detailed rebuttal of the allegation in a nineteenth century publication of theft by a president of the college. Sir Henry Halford had been one of the experts at the reopening of the coffin of Charles I, and rumour alleged that he had purloined the fourth cervical vertebra, split by the executioner's axe, and kept it to amuse dinner guests. Certainly Sir Henry possessed the bone, but his own account of how he got it seems far more plausible than the smear story. The vertebra is now back on the coffin.

Another more recent but equally inaccurate rumour concerns the death in 1937 of the composer George Gershwin. When he developed headaches and incoordination he consulted two psychoanalysts, who were later blamed for delay in the recognition of the cause, a malignant brain tumour. In fact, says Lawrence K Altman in a recent article in the "New York Times," both psychiatrists recognised the organic basis of his symptoms: the delay came from Gershwin's own refusal to undergo diagnostic tests—and in any case the tumour would probably have been fatal however quickly it had been treated.

Injuries of the hand are quite common in basket-ball players. Tall men are particularly liable to nasty lacerations when they attempt to "dunk" the ball (*Journal of the American Medical Association*, 1979, **242,** 415) because they catch their hands on damaged metal brackets that are meant to hold the basket in place.

A pharmaceutical research institution should ideally have between 300 and 1000 staff—at an annual cost of several million pounds—according to Dr M Weatherall. The recently retired director of establishment at Wellcome Research Laboratories was arguing at a London symposium, reported in the "Pharmaceutical Journal" earlier this month, that fewer than 300 people were inadequate for effective research and a staff of over 1000 had communication problems that outweighed any advantages of scale.

Even unsuccessful attempts to treat cancer with vitamin C are bound to be newsworthy, not least because the idea has been championed by Nobel Prize winner Linus Pauling. Using 10 g a day in the first double-blind controlled trial (*New England Journal of Medicine*, 1979, **302,** 687), American workers could find no benefit in patients with advanced disease, though they say that previous treatment may have masked any enhancement of the immune apparatus by vitamin C. But, interestingly, those who took either vitamin C or placebo survived twice as long as those who refused randomisation—the only significant result in the trial, and a reminder that differences in outcome may be unrelated to management.

Before Mr Patrick Jenkin gets carried away by his campaign against social security scroungers he should, Minerva thinks, read the opening article in the current "British Journal of Psychiatry" (1979, 135, 289). This account of the realities of the Welfare State describes an appalling Wiltshire kindred of 40 members with their spouses and cohabitees, many of subnormal intelligence, who absorbed astronomical amounts of time, money, and effort from social and welfare agencies for at least two decades to no avail whatever. Over three generations the children were battered, starved, and neglected, and seven died: at least three-quarters of the survivors developed severe behaviour disorders and most progressed to become adult criminals.

A young man grazed his leg playing football and the wound was infected by the normally harmless soil fungus *Curvuleria lunata*. Over the course of the next 10 years abscesses appeared in the deep tissues, lungs, and brain (*Archives of Internal Medicine*, 1979, **139,** 940) and innumerable courses of treatment with drainage, miconazole, and amphotericin B failed to eradicate them completely.

Why has the DHSS published (price £2·00 and at taxpayers' expense) a 112-page account of a study of doctor-patient relationships in general practice? The report is written in nearly incomprehensible sociologobabble ("The doctor's presentation of his role begins with the way he structures the area in which he works . . ."), which makes it much longer than necessary. Why wasn't it written for and submitted to a recognised journal? Another item for Mr Jenkin's reading list.

Reading L N Payne's fascinating account of Marek's disease or fowl paralysis (*Journal of the Royal Society of Medicine*, 1979, **72,** 635), Minerva couldn't help thinking that people fared worse than chickens. Commercial pressures to solve a disease with an 80% mortality led in eight years to the cause (a herpesvirus) and to production of a highly successful vaccine. Meanwhile doctors struggle on, trying to understand its near relatives—infectious mononucleosis, Burkitt's lymphoma, nasopharyngeal carcinoma, and Guillain-Barré syndrome.

In the United States violence (suicide, homicide, and accidents) is now the leading cause of death up to the age of 40; and the past two decades have seen death rates in adolescents from suicide and homicide double while deaths from accidents have remained constant. Why, asks an article in the "American Journal of Psychiatry" (1979, 136, 1144), is so little attention paid to the investigation and possible prevention of this phenomenon?

Insulin resistance is usually due to circulating antagonists or a defective peripheral response. A patient has now been found who apparently secretes an abnormal insulin in which there may be a simple substitution of leucine for phenylalanine in the biologically active part of the molecule (*Nature*, 1979, **281,** 122). If this is confirmed in other patients the geneticists might regain some of the ground lost to those who believe diabetes to be due to a virus infection.

MINERVA

EPIDEMIOLOGY

Gastroenteritis of unknown aetiology

Prepared by the Food Hygiene Laboratory and the Communicable Disease Surveillance Centre, Public Health Laboratory Service, Colindale.

Despite careful investigation, pathogens are by no means always isolated in outbreaks of gastroenteritis. For example, in May of this year 30 women attended a club meeting held at one of the members' homes. An evening buffet of prawn cocktail, cold meats, turkey paté, egg mayonnaise, mushroom vols au vent, quiche Lorraine, various salads, cherry pie, gateaux, fresh fruit salad, and cream was served.

About 30-40 hours later many of the women became ill and 29 were contacted. Only four of these were symptom-free; most of the others had nausea and vomiting, 13 had abdominal pain, 10 had diarrhoea and vomiting, and nine had diarrhoea without vomiting. Food histories were available from 27 of the women, but statistical analysis of attack rates was of limited value since most people had eaten a little of each food and only four people were known not to be ill; nevertheless, the consumption of one food—egg mayonnaise—was found to be significantly associated with illness ($P=0\cdot01$), using exact probabilities.

The food had been prepared at the home of one of the professional caterers with only the final preparation and serving at the house where the food was eaten. The local environmental health officers were satisfied with the methods of preparation and storage of the food before serving, though the methods stated could not be verified. None of the food was available for examination. No gastrointestinal pathogens, including salmonella, shigella, and campylobacter, were isolated from the faeces of 13 patients and the catering staff. Electron microscopy of faeces from six patients gave negative results for virus particles.

Other recent outbreaks

During the past 12 months the Food Hygiene Laboratory at Colindale has been concerned in the investigation of 10 outbreaks of gastroenteritis which appeared to be associated with food but in which a causative agent was not identified.

In all 10 outbreaks faecal samples were examined in public health or hospital laboratories for the presence of the more common food poisoning bacteria but, apart from the expected isolation of small numbers of *Clostridium perfringens*, none was found. Faecal specimens from three of the outbreaks were examined by electron microscopy for viruses but the results were negative. No pathogenic bacteria were isolated from food samples obtained from six of the outbreaks. In several of the outbreaks a wide range of foods had been served as a cold buffet, and therefore it was difficult to incriminate any one food as the suspected vehicle of infection. Although it is unlikely that the same agent (bacterial or viral) was responsible for all these episodes, there were nevertheless several similarities. In most of the outbreaks, the incubation period ranged from 24 to 48 hours and the illness tended to last two to three days. Vomiting was the main symptom, and other symptoms included diarrhoea and varying degrees of nausea, abdominal pain, and fever.

Clearly such outbreaks should not be ignored. A thorough investigation should include examination of food and faecal samples for both bacteria and viruses. A full history is also important when possible, both from those affected and those who are symptom-free to enable food-specific attack rates to be calculated. By this means a specific food can often be incriminated even though the results of microbiological investigations may have proved negative.

MEDICOLEGAL

Negligence and the unborn child

FROM OUR LEGAL CORRESPONDENT

"The development of medical and social services has led to more and more women seeking medical advice during pregnancy. This . . . is bound to lead to greater risks of medical advisers failing to tender the correct advice or to prescribe and give the correct treatment."

Those were the Law Commission's words, written in 1974 for the Report on Injuries to Unborn Children.[1] They rightly anticipated an area of growing pressure on the medical profession and at the same time a rich new seam of litigious ingenuity. No one doubts that a pregnant woman has a cause of action if she herself is injured by negligent medical treatment. The controversial question centres on the child's standing to sue for antenatal negligence. Can the child sue for disabilities caused by antenatal maltreatment? And, secondly, can a child born with a disability caused not by medical or other negligence but by some congenital defect raise a cause of action against a doctor who could have detected the likelihood of disability and advised termination of the pregnancy, but who negligently failed to put the facts before the parents, as a result of which the child was born and not aborted?

Decisions abroad

In South Africa, Canada, Australia, and the United States infant plaintiffs have succeeded in actions for injury caused by antenatal negligence, but there appears to have been no decided case on the point in England or in Scotland, and the common law both here and in the Commonwealth was long hostile to the new development. In 1933, for instance, a Canadian judge[2] declared: "The great weight of judicial opinion in the common law courts denies the right of a child when born to maintain an action for pre-natal injuries." It was probably the absence of English authority that brought the thalidomide actions to settlement: though Distillers strongly denied negligence, they made no attempt to avoid liability altogether by denying that the children had any cause of action for their deformities.[3] As the commentator[4] observed in the report of a similar action settled in 1939, "where the law is obscure and where it most needs clarification, there are litigants most nervous of the courts." In that case a pregnant woman was injured by a ladder which fell from a Liverpool cinema and as a result gave birth to a child which died a day later. The mother sued as the dead child's administratrix, but as the action was settled for £100 at the door of the court no trial took place. Counsel for the plaintiff expressed some regret that so interesting a point of law was not to be decided: the judge replied with feeling that it was not a regret that he personally shared.

Status of unborn child

These settlements at least pointed the way for English law, and in addition by 1960 most American States had abandoned their early concern that the unborn child was merely part of its mother and not, therefore, a person-in-being to whom a duty was owed. In that year a New Jersey judge[5] declared: "The semantic argument whether an unborn child is a 'person-in-being' seems to us to be beside the point. . . . Justice requires that the principle be recognised that a child has a legal right to begin life with a sound mind and body."

In the early 1970s, there was still no decided English authority on what was bound to become a more and more contentious question, and the then Lord Chancellor asked the Law Commission to investigate. Its report was followed by the enactment in 1976 of the Congenital Disabilities (Civil Liability) Act.[6] Under the Act, anyone responsible for an occurrence affecting the parent of a child causing that child to be born disabled will be liable in tort to the child if he would have been liable to the parent. So there is no new area of duty—liability to the child hangs on liability to the parent. The Act explicitly states[7] that a professional man will be under no liability to the child for treatment or advice given to the parent "if he took reasonable care having due regard to then received professional opinion applicable to the particular class of case." No doubt that passage will provide scope for argument, but the subsection does continue: "This does not mean that he is answerable only because he departed from received opinion."

To embark on an action under the Act the infant plaintiff must have been born alive.[8] The alternative would have meant investing the fetus with a legal personality, so making awkward bedfellows of this legislation and the Abortion Act. As one academic commentator[9] has observed, there is paradox enough in the present position: liability is incurred for negligent injury to the fetus, but not—or at least not necessarily—for its deliberate destruction.

"Wrongful life"

The more difficult question is how the courts are likely to view a claim by a child, suing through its next friend, that the doctors negligently failed to spot a preexisting fetal deformity, and to advise accordingly, so that the child was not aborted but was born deformed. The doctors cannot be blamed for the deformity—only for the live birth. No doubt duty of care, breach of duty, and causation could be established, but on damages the courts are faced with a near impossible question: is it better not to be born at all than to be born disabled? Some decisions have been made by courts in the United States. In Williams *v* State of New York[10] an illegitimate child had been born (as a result of a sexual assault) to a mentally deficient mother in the care of a State hospital. The plaintiff child alleged that the State was negligent in failing to protect her mother and thus in allowing her to bear the stigma of illegitimacy. The court dismissed the claim, finding it impossible to decide whether non-existence was preferable to existence as an illegitimate child. In two other cases before the New York Court of Appeals, the court refused to permit such children to sue, on the basis that they had suffered "no legally cognisable injury." The court went on: "Whether it is better never to have been born at all than to have been born with even gross deficiencies is a mystery more properly to be left to the philosophers and the theologians. . . . Simply put, a cause of action brought on behalf of an infant seeking recovery for wrongful life demands a calculation of damages dependent upon a comparison between the Hobson's choice of life in an impaired state and non-existence. This comparison the law is not equipped to make."

In Britain this point is covered by the 1976 Act. Section (2) (b) states: "An occurrence to which this section applies is one which . . . affected the mother during her pregnancy, or affected her or the child in the course of its birth, so that the child is born with disabilities which would not otherwise have been present." This wording assumes that, but for the occurrence giving rise to the disabled birth, the child would have been born normal and healthy—not that it would not have been born at all. That this was the Law Commission's intention is clear from its conclusion and the reasons it gave: "We do not think that, in the strict sense of the term, an action for 'wrongful life' should lie. Such a cause of action, if it existed, would place an almost intolerable burden on medical advisers in their socially and morally exacting role. The danger that doctors would be under subconscious pressures to advise abortions in doubtful cases through fear of an action for damages is, we think, a real one. It must not be forgotten that, in certain circumstances, the parents themselves might have a claim in negligence."

That very danger of "subconscious pressures" does now exist, though not in the form of an action by the child. It has loomed since the New York cases, where the distasteful claims for "wrongful life" were rejected, but the children's parents were allowed to proceed in their claim for monetary expenses for the care and treatment of the disabled children who, through negligent failure to advise abortion, were born alive. As a matter of fact, one child died soon after birth, and the other was soon given up for adoption, so predictions of a multi-million-dollar verdict were unfulfilled.

In 1979 judgment was given in the English High Court[12] for a woman plaintiff who in 1972 had contracted with the defendant doctor for the legal termination of her pregnancy. The doctor operated but failed to terminate; consequently in December 1972 the woman had given birth to a healthy child. She sued for damages for breach of contract, claiming that the doctor had negligently performed the operation and failed to carry out the necessary further investigations, procedures, and treatment. The child's father refused to marry the woman, so she had had to bring up the child alone. She was awarded damages of £18 750, made up of £7000 loss of earnings up to trial, £7500 for future loss of earnings, £3500 for loss of marriage prospects, and £750 for pain and suffering, including anxiety and distress.

This was an action for breach of contract, not for negligence. On the other hand, the judge expressly stated that there was no public policy reason to preclude the plaintiff from recovering damages, and there is the further point that the child was healthy: a fortiori, an action would lie for the disabled, and no doubt damages would be greater still. There is no obvious reason why the English courts should not allow recovery in tort by a woman plaintiff for monetary loss caused by a doctor's negligent failure to detect fetal abnormality, or, having detected it, to advise the patient accordingly so that the fetus could be aborted. The assessment of damages, which the Law Commission regarded as an impossibility in the case of "wrongful life," becomes a straightforward matter of projecting monetary loss. It might be argued that there can be no duty of care to advise of the availability of therapeutic abortion unless the mother's life or health is in imminent danger, but that would be a difficult argument to sustain. The "conscientious objection" section of the Abortion Act would not provide a defence to a claim for negligent failure to advise that therapeutic abortion is available, for the section (S4) says that nobody is under a duty, whether by contract or by any statutory or other legal requirement, to participate in any treatment authorised by the Act to which he has a conscientious objection. It is not likely that the words "participate in" can be stretched to include informing a patient that, in the doctor's opinion, she meets the legal requirements for therapeutic abortion.

Just possibly the Court of Appeal might prove reluctant to endorse recovery of damages in circumstances which would place on doctors those "subconscious pressures to advise abortions in doubtful cases"—or indeed, in the case of doctors troubled by the moral propriety of abortion, more complex pressures still, and not merely subconscious ones; but it is more likely, now that it has been decided that public policy considerations need not stand in the way of recovery of damages in contract for the birth of a perfectly healthy, normal child, that a new field of litigation has been opened up.

1 Law Commission No 60. London, HMSO, 1974, Cmnd 5709.
2 Lamont, J, in *Montreal Tramways v Leveille* (1933) SCR 456; 4DCR 337. This was a case in which the plaintiff's mother was injured in a tram accident. As a result, the plaintiff was born with club feet. The plaintiff succeeded in the claim, but the decision turned on the question of the unborn child's "existence" within the provisions of the Quebec Civil Code, and thus lacked cogency in England.
3 *S v Distillers Company (Biochemicals) Limited* (1970) 1 WLR 114.
4 *Davies v British Picture Corporation Ltd* (1939) SJ 185.
5 *Smith v Brennan and Galbraith* (1960) 31 NJ 353.
6 Congenital Disabilities (Civil Liability) Act 1976, c 28.
7 S1(5) Congenital Disabilities (Civil Liability) Act 1976, S1(5).
8 S4(2) Congenital Disabilities (Civil Liability) Act 1976, C54(2).
9 Pace, *Civil Liability for Pre-Natal Injuries* (1977) 40 MLR 141.
10 18 NY 2d 481 (1966); 46 ONYS 2d 953 (1965).
11 *Becker v Schwartz* No 559 27 December 1978. *Park v Chessin* No 560 27 December 1978.
12 *Scuriaga v Powell* (1979) 123 SJ 406; (1979) 6 CL 53, 293.

MEDICAL NEWS

Health Commissioners win over consultation

Lewisham Council last week lost its case in the High Court against the Lambeth, Southwark, and Lewisham Health Commissioners over the closure of St John's Hospital, Lewisham. The council had challenged the right of the commissioners to close the hospital without consulting the community health council and other interested bodies. Mr Justice Griffiths agreed that the closure was a substantial variation in service but ruled that the commissioners were within their rights not to consult since they had made their decision to close the hospital quickly and without consultation in the interests of the Health Service. Before the hearing the commissioners had held a special meeting to rethink their plans, but they did not change their decision over St John's, which was due to close this week.

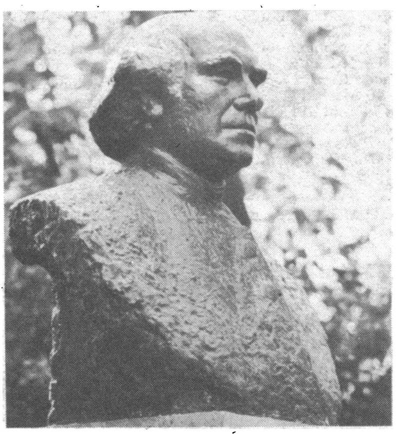
Lewisham Council is meanwhile joining Southwark and Lambeth councils to challenge the Secretary of State's right to remove the powers of the AHA(T)'s members and to appoint commissioners in their place. Southwark council has obtained counsel's opinion that there is a prima facie case that the Secretary of State was not within his rights in acting under the emergency provisions of section 86 of the National Health Service Act 1977. If the three councils are successful in their action, which should be heard in the next week or two, all the decisions made by the commissioners would be null and void.

Need to preserve FPCs

In his address to the annual conference of the Society of Family Practitioner Committees, the president, Dr Lionel Kopelowitz, criticised the Royal Commission's recommendation to abolish family practitioner committees. In support of his view, Dr Kopelowitz quoted one of the commission's own research papers, *The Working of the NHS*, which had stated, "To judge from the examples of Northern Ireland and Scotland . . . the integration of the family practitioner services within an area health authority did not lead to reports of better integration of planning and practice." The

FPCs and their predecessors, the executive councils, had stood the test of time, he claimed, and the equal balance of lay and professional representation, with the resulting simple administrative structure, had commanded the confidence of the public and the profession. "We have," Dr Kopelowitz said, "personal contractors providing personal services in personal surroundings, and we are perhaps the last bastion of the personal approach in an otherwise impersonal world."

Bust of John Hunter



A bust of John Hunter in Lincoln's Inn Fields, presented by the President of the Royal College of Surgeons of England, Sir Reginald Murley, to representatives of the London Borough of Camden on 10 October. The bust, by Mr Nigel Boonham, is one and a half times life size and is cast in bronze. The following inscription appears on a plaque: "This bust of John Hunter (1727-93), the founder of scientific surgery, whose Museum is housed in the Royal College of Surgeons of England, is a gift of the President and Council of the College made in 1977 to record their appreciation of the pleasure and satisfaction that the College's long association with Lincoln's Inn Fields (since 1796) has given to successive generations of Fellows, Members, students and staff; and to mark the celebrations of the Silver Jubilee of Her Majesty Queen Elizabeth II, Visitor and Honorary Fellow of the College."

Henry Miller memorial concert

The many friends and colleagues of the late Dr Henry Miller may wish to know that this year's Henry Miller memorial recital, which is to be given by Sheila Armstrong (soprano) accompanied by Martin Isepp, will be held in the King's Hall of the University of Newcastle upon Tyne at 6 pm on 9 November. These annual concerts have been endowed with the aid of generous donations received from many of Henry Miller's friends and admirers from all parts of the world. Anyone who would like to attend the recital should contact Sir John Walton's secretary at the medical school (0632 28511). The recital will be a public one, but a limited number of seats are being reserved.

Agricultural medicine

The newly formed Rehabilitation Trust of Great Britain has given official recognition to agricultural medicine. This embraces the identification, diagnosis, prevention, and treatment of conditions arising from man's contact with agriculture or land-based work; and it therefore concerns doctors, veterinary surgeons, agricultural engineers, toxicologists, epidemiologists, environmental health officers, and others. A short-term aim of the new trust is to study the needs of the agriculturist for rehabilitation, and the longer-term objective is to found an institute of agricultural medicine. Those who are interested in the subject are invited to write to Dr C K Elliott (West Walton, Wisbech, Cambs PE14 7EU) so that a meeting can be arranged. When the extent of professional interest in agricultural medicine is known the possibility of forming a British delegation to the International Association of Agricultural and Rural Health will be considered.

COMING EVENTS

Middlesex Hospital Medical School—Meeting "Abortion under attack," on the Corrie amendment, 25 October, London. Details from Lindsey Dav, Middlesex Hospital Medical School, Cleveland Street, London W1.

Royal College of Physicians of London—Clinicopathological conference, 25 October, London. Details from the conference secretary of the college, 11 St Andrew's Place, Regent's Park, London NW1.

London Boroughs' Training Committee (Social Services)—Colloquium workshop "Management of integrated care between hospital and general practice," 1 November, Croydon. Details from Mrs E Evans, London Boroughs' Training Committee, 3 Buckingham Gate, London SW1E 6JH, tel 01-828 8176; or Dr J Keet, Queen's Hospital, Croydon, Surrey, tel 01-689 2211.

Institute of Obstetrics and Gynaecology—Symposium "Amniotic fluid and its clinical significance," 2 November, London. Details from the symposium secretary, Institute of Obstetrics and Gynaecology, Queen Charlotte's Maternity Hospital, Goldhawk Road, London W6 0XG. (Tel 01-748 6802 ext 355.)

5th Congress of the Medical Oncology Society—1-3 December, Nice. Details from the secretariat, F Fein, Bibliothèque, Centre Antoine-Lacassagne, 36 Voie Romaine, 06054 Nice Cedex, France. (Tel (93) 81 71 33 ext 248.)

Pakistan Medical Association Clinical Conference—20-21 December, Lahore. Details from Dr Mubarak Ahmad, Pakistan Medical Association, 66 Ferozepur Road, Lahore, Pakistan.

"Communication and cancer education"—Symposium organised by the Tenovus Cancer Information Centre and South Glamorgan Health Authority (Teaching), 18-20 March 1980, Cardiff. Details from Mrs S P Berry, Tenovus Cancer Information Centre, 90 Cathedral Road, Cardiff. (Tel 0222 42851.)

Instructional course in hand surgery—24-26 April 1980, Windsor. Details from Stewart H Harrison, Esq, FRCS, 1 Dorset Road, Windsor, Berks.

Fourth International Congress of Immunology—21-26 July 1980, Paris. Details from the administrative secretariat, Congrès-Services, 1 rue Jules-Lefebvre, 75009 Paris, France.

"Geriatric care: a total approach"—Details of 20 short courses on geriatric care organised by the University of Birmingham Department of Geriatric Medicine and Gerontology and the Department of Extramural Studies are available from Professor B Isaacs, University Department of Geriatric Medicine, Hayward Building, Selly Oak Hospital, Birmingham B29 6JD.

SOCIETIES AND LECTURES

*For attending lectures marked * a fee is charged or a ticket is required. Applications should be made first to the institutions concerned.*

Monday, 22 October

Institute of Dermatology—4.30 pm, Mr K W Lee: The biology of the oral mucosa.

Institute of Obstetrics and Gynaecology—At Queen Charlotte's Hospital, 12.30 pm, Mr M Gillmer: The diagnosis and management of diabetes mellitus in pregnancy.

Tuesday, 23 October

Institute of Dermatology—4.30 pm, Dr R A J Eady: The melanocyte system and mechanism of melanin pigmentation.

Society for the Study of Addiction—At King's College London, 5.30 pm, J Y Dent memorial lecture in pharmacology by Professor J Griffith Edwards: Opium and after.

Wednesday, 24 October

Institute of Neurology—Sandoz Foundation advanced lectures, 6 pm, Professor J A Lucy: Membrane abnormalities in muscular dystrophy. 7 pm, Professor V Dubowitz: Muscle disorders in children.

Institute of Orthopaedics—6 pm, Mr J Crawford Adams: Intramedullary nailing of the tibia and other long bones. 7 pm, Mr J N Wilson: Elbow injuries.

Institute of Psychiatry—5.30 pm, Dr S N Wolkind: The origins of childhood disturbance.

University College London—5.30 pm, Professor G A Horridge (Australia): The compound eye as an organ adapted to seeing.

University of Oxford—At John Radcliffe Hospital, 5 pm, medical consilia, Professor Earl Benditt (USA): Atheroma.

Westminster Hospital—1 pm, Dr D Von Hoff: Human tumour stem cell systems, a predictor of clinical response in cancer?

Thursday, 25 October

St Mary's Hospital Medical School—5.15 pm, Aleck Bourne lecture by Professor H M Carey (Australia): The "tailor-made" pill.

West of Scotland Committee for Postgraduate Medical Education Centre for Medical Women—9.30 am, Mr G M Teasdale: Neurosurgery today.

BMA NOTICES

Central Meetings

	OCTOBER
24 Wed	Consulting Pathologists Group Committee, 2.15 pm.
25 Thurs	Superannuation Committee, 10.30 am.
	NOVEMBER
1 Thurs	Accident and Emergency Subcommittee (CCHMS), 2 pm.
14 Wed	General Purposes Subcommittee (CCHMS), 2 pm.
15 Thurs	General Medical Services Committee, 10 am.
15 Thurs	Negotiating Subcommittee (CCHMS), 10 am.
21 Wed	Mental Health Group Committee, 9.30 am.
21 Wed	Finance and General Purposes Committee, 10 am.
28 Wed	**Council**, 10 am.

Division Meetings

*Members proposing to attend meetings marked * are asked to notify in advance the honorary secretary concerned.*

Bradford and Airedale—At Bradford Royal Infirmary, Wednesday, 24 October, 7.30 pm, Dr G A Bell: ". . . so that's what you do!"

Clwyd North—At Glan Clwyd Hospital, Tuesday, 23 October, 6.30 pm, conducted tour of hospital. (Wives and guests invited.)

Chester, Crewe, Macclesfield, and Warrington Divisions—At Leighton Hospital, near Crewe, Wednesday, 24 October, 7.30 for 8 pm, meeting on industrial relations, speaker Mr Norman Ellis.

East Surrey—At Redhill General Hospital, Tuesday, 23 October, 7.30 pm, Dr Alex Sakula: "Rene Theophile Hyacinthe Lannec and the history of the stethoscope."* (Supper provided.)

Fife—At Station Hotel, Kirkcaldy, Friday, 26 October, 8 pm, BMA dinner and dance.*

Lincoln—At White Hart Hotel, Thursday, 25 October, 7.45 for 8.15 pm, social evening.* (Guests invited.)

Manchester and Salford—At Boyd House, Tuesday, 23 October, 8 for 8.30 pm, Dr K B Carroll: "Asthma."* (Supper provided.)

Mid Essex—At Chelmsford and Essex Hospital, Wednesday, 24 October, 8 pm, annual lecture by Professor N Dilly: "Expedition medicine, a catalogue of disasters."* (Buffet 7.30 pm.* Guests are invited.)

North-west Essex—At Princess Alexandra Hospital, Harlow, Wednesday, 24 October, 8.30 pm, Dr L Cohen: "Contact dermatitis and use and abuse of steroids."

Oxford—At John Radcliffe Hospital, Wednesday, 24 October, 8.30 pm, Dr R A Thompson: "Immunology in Britain today."

Scarborough—At Royal Hotel, Friday, 26 October, 7.45 for 8.15 pm, dinner and dance.* (Guests are invited.)

Trafford—At St Anne's Hospital, Altrincham, Wednesday, 24 October, 7.30 pm, Dr John Dawson: "Recent changes in medical ethics."

Wandsworth and East Merton—Tuesday, 23 October, 6.45 for 7 pm, clinical meeting.

Regional Meetings

Lothian Area Hospital Consultants and Specialists Committee—At BMA Scottish House, Monday, 22 October, 7.30 pm.

Northern Region Medical Assistants Group—At Medical Institute, Newcastle upon Tyne, Friday, 26 October, 7 pm.

Regional Group Central Committee for Community Medicine South-east Thames Regional Group—At Preston Hall Hospital, Wednesday, 24 October, 6.30 pm.